APPENDIX A

IN THE DISTRICT COURT OF APPEAL
FIRST DISTRICT
STATE OF FLORIDA

Case No. 94-51

EDISON M. FURTICK, JR.,
Appellant,
v.

WILLIAM SHULTS CONTRACTOR and
EXECUTIVE RISK CONSULTANTS, INC.,
Appellees.

Opinion filed November 16, 1995

Appeal from an order of the Judge of Compensation Claims. C. Douglas Brown, Judge.

PER CURIAM:

The claimant appeals a workers' compensation order by which the judge dismissed a claim for payment of past medical bills,[1] finding that the dispute involved a question of overutilization within the exclusive jurisdiction of the Division of Workers' Compensation (the division). Because we agree that the claimant's out-of-state doctor is subject to utilization review procedures under the Florida Workers' Compensation Law, and that the

[1] The formal claim also refers to "continuing" medical, but the dispute was thereafter limited to past medical as of the date of the hearing.

issues as presented otherwise addressed matters within the scope of the utilization review process, we conclude that the judge properly determined that he lacked jurisdiction.

The claimant sustained an industrial injury which was accepted as compensable under the Florida Workers' Compensation Law. The employer furnished medical care through a series of providers, including an out-of-state doctor. The employer's servicing agent conducted a utilization review of this doctor's care, and subsequently disallowed reimbursement for certain billings by referencing the requirement in the division's Reimbursement Manual that such services be medically necessary. The claimant thereafter proceeded to a hearing before the judge of compensation claims, seeking to compel payment for the services for which reimbursement had been disallowed.

In accordance with section 440.13(4)(i)3, Florida Statutes (1993), the doctor's care was subject to the utilization review process in section 440.13. The statute addresses two levels of utilization review, as such review may be conducted by either an employer/carrier or the division. *See* § 440.13(2)(i); § 440.13(2)(j)1, Fla. Stat. (1993). While the division may initiate its own review and is independently empowered to investigate health care providers and facilities pursuant to section 440.13(4)(h), Florida Statutes (1993), it also entertains proper requests for utilization review. § 440.13(2)(j)1; § 440.13(4)(i)1, Fla. Stat. (1993). This process encompasses reimbursement disputes as referenced in section 440.13(2)(j)1 and 2. *See* Fla. Admin. Code R. 38F-7.507(1)(c). If such disputes remain unresolved after an employer/carrier's in-house review, they may be submitted for further review by the division. *See* Fla. Admin. Code R. 38F-7.518.

Consistent with section 440.13(4)(i)1 and 2, Florida Statutes (1993), utilization review (in both the concurrent and retrospective mode) pertains only in connection with care which has been authorized, as when the

employer/carirer has paid or incurred an obligation to pay for the doctor's services. Because section 440.13(3), Florida Statutes (1993), insulates the claimant from liability in such circumstances, the health care provider (or facility) and the employer/carrier are the parties with the legal interest affected by utilization review. *See Long Grove Builders v. Haun,* 508 So. 2d 476 (Fla. 1st DCA 1987). Reimbursement disputes within the scope of utilization review must thus be pursued as between the provider (or facility) and the employer/carrier in the administrative forum, and such matters may not be pursued before the judge of compensation claims. *Terners of Miami v. Freshwater,* 599 So. 2d 674 (Fla. 1st DCA 1992); *Lamounette v. Atkins,* 547 So. 2d 1001 (Fla. 1st DCA 1989); *Long Grove.* An employer/carrier may deauthorize a provider's care [2] upon a determination of overutilization after in-house review, *see* section 440.13 (2)(c), Florida Statutes (1993), but such a determination remains subject to the division's oversight if the provider requests subsequent review by the division. The judge of compensation claims retains the authority to resolve disputes regarding the claimant's medical status, *see Carswell v. Broderick Const.,* 583 So. 2d 803 (Fla. 1st DCA 1991), and the claimant may therefore pursue relief before the judge in connection with a continued need for medical services, including authorization issues relating to further care.

In the present case the doctor was not deauthorized, but payment was disallowed on certain billings for care

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[2] Cases such as *Williams v. Triple J. Enterprises,* 650 So. 2d 1114 (Fla. 1st DCA 1995), which indicate that the employer is limited in deauthorizing medical care under an existing doctor-patient relationship, must be read in light of cases such as *Cal Kovens Const. v. Lott,* 473 So. 2d 249 (Fla. 1st DCA 1985), which more thoroughly explain that when such deauthorization is made over the claimant's objection the employer incurs the risk that the judge may subsequently find such deauthorization to be without good cause. *See also* § 440.13(2)(d); § 440.13(3), Fla. Stat.

which had been provided. Unlike *Williams v. Triple J Enterprises*, 650 So. 2d 1114 (Fla. 1st DCA 1995), where a claimant was seeking recoupment of monies personally expended for medical care, the present case involves a reimbursement dispute between the doctor and the employer so as to be within the scope of utilization review. This does not permit the employer to interject issues such as compensability, causal relation, etc., into the utilization review process, as these matters do not avoid a payment obligation for care which has been authorized. *See Platzek v. Rock-a-Way, Inc.*, 512 So. 2d 233 (Fla. 1st DCA 1987). Instead, utilization review addresses the appropriateness of the level and quality of care, based on medically accepted standards. § 440.13 (1)(i), Fla. Stat. (1993). Any inquiry into medical necessity in this context is generally limited to whether the care is appropriate to the diagnosis,[3] as within the range of reasonable practice parameters accepted by the doctor's peers. *See* § 440.13(1)(d), Fla. Stat. (1993).

As in *Carswell* and *Long Grove*, the reimbursement dispute which the parties presented below involved matters of utilization review outside the realm of the judge's jurisdiction. The appealed order is therefore affirmed.

BARFIELD and ALLEN, JJ., and SMITH, SENIOR JUDGE, CONCUR.

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[3] Questions as to the diagnosis itself, apart from whether it was made within reasonable practice parameters, must be pursued before the judge of compensation claims. This would ordinarily involve a medical dispute within the ambit of section 440.13(2)(j) 3.a, Florida Statutes (1993).

APPENDIX B

DISTRICT COURT OF APPEAL
FIRST DISTRICT

Tallahassee, Florida 32399
Telephone No. (904) 488-6151

December 21, 1995

Case No: 94-00051

L.T. Case No. 267-88-8230

EDISON M. FURTICK, JR.,
Appellant(s),

v.

WILLIAM SHULTS, CONTRACTOR & ERC,
Appellee(s).

BY ORDER OF THE COURT:

Motion for rehearing and/or clarification and motion for rehearing en banc and motion for certification, filed December 1, 1995, is DENIED.

I HEREBY CERTIFY that the foregoing is (a true copy of) the original court order.

/s/ Jon S. Wheeler
JON S. WHEELER
Clerk

By: /s/ Sandra Joyner
Deputy Clerk

APPENDIX C

[Dec. 9, 1993]

STATE OF FLORIDA
DEPARTMENT OF LABOR AND
EMPLOYMENT SECURITY

OFFICE OF THE JUDGE OF COMPENSATION CLAIMS
DISTRICT A CENTRAL

Claim No.: 267-88-8230

D/A: 01/10/85

EDISON M. FURTICK, JR.,
Claimant

vs.

WILLIAMS SHULTS, CONTRACTOR & ERC,
Employer/Carrier

ORDER

Pursuant to notice the final hearing was held in Panama City July 6, 1993. The parties were granted leave to file post-hearing memorandum. Upon receipt, the evidence was reviewed. A letter was directed to counsel on September 14, 1993, containing proposed rulings and requesting supplemental memorandums which were subsequently filed. At the hearing the parties stipulated Dr. Phillips testimony regarding reasonableness and necessity for services after the deposition would be the same as given in the depoistion for prior services. The following exhibits were placed into evidence:

CLAIMANT'S EXHIBIT #1: Deposition of Sandie Firestone;

CLAIMANT'S EXHIBIT #2: Deposition of Dr. Phillips;

CLAIMANT'S COMPOSITE EXHIBIT #3: E/SA response to Request for Production;

CLAIMANT'S EXHIBIT #: Deposition of Amy Goodbread:

1. The E/SA filed a motion to dismiss asserting lack of jurisdiction. The E/SA contends the sole issue is overutilization and jurisdiction is exclusively vested in the Division of Workers' Compensation. Claimant contends Dr. Phillips, an out of state chiropractor, is not subject to the overutilization process under Florida workers' compensation law for the same reason out-of-state practitioners are not limited by the Florida medical fee schedule. Claimant further argues there is no *in personam* Florida jurisdiction over Dr. Phillips based on lack of minimum contacts. My letter of September 14, 1993 to counsel is attached hereto and made a part hereof. As stated therein minimum contacts is a constitutional question over which I have no jurisdiction.

2. The case law recognizes the legislative decision to divide jurisdiction between the Division of Workers' Compensation and the Office of Judge of Compensation Claims in medical disputes. *Wolk v. Jaylen Homes, Inc.*, 593 S. 2nd 1058 (Florida 1st DCA 1992) summarizes that division of responsibility as follows:

> "Under the Act, it is the Division's duty to: (1) establish the fee schedule, (2) determine compliance of health care providers with that schedule, (3) interpret procedures under that schedule, and (4) resolve disputes concerning excessive treatment i.e. gouging. It is the duty of the Judge of Compensation Claims to: (1) assure that the claimant receives appropriate medical treatment, (2) authorize health care providers where there is a dispute between claimant and employer/carrier (3) approve payment of medical bills presented in proper form, and (4)

resolve conflicts between health care providers regarding a claimant's medical status."

Overutilization issues fall under the jurisdiction of the division of workers' compensation, *Carswell, Atlantic Foundation v. Gurlacz,* 582 So. 2nd 10 (Fla 1st DCA 1991), *Lamounette v. Akins,* 547 So. 2d 1001 (Fla 1st DCA 1989), and *Terners of Miami Corporation v. Freshwater,* 599 So. 2nd 674 (Fla 1st DCA 1992). An exception is recognized in *Wolk, supra,* where the E/C unilaterally deauthorized the health care provider without complying with the utilization review procedures prescribed by statute and administrative rules. Issues of deauthorization in that context remain within the jurisdiction of the JCC.

3. In this case the E/SA never deauthorized Dr. Phillips. The adjuster's deposition states he remains authorized. Viewing that issue from the perspective of substance over form claimant argues fairly persuasively the SA's actions effectively deauthorize Dr. Phillips because it has refused to pay all his bills after a certain date based on a consultant's report that on going chiropractic treatment is not justified. The E/SA argues Dr. Phillips not only remains authorized but will be paid for appropriate charges stemming from medically necessary treatment. There is no clue in the record of what palliative treatment the E/SA considers to be medically necessary at this point. Claimant testified he is able to function with the treatment but doubts he could without it. Because the E/SA actions with regard to Dr. Phillips bills for services have been couched in terms of overutilization and there has been no statement of deauthorization, I conclude Dr. Phillips has not been deauthorized to bring the case within the framework of *Wolk, supra.*

4. It is obvious the SA has not complied with the overutilization administrative rules in many respects. Those shortcomings are enumerated in the excellent supplemental memorandum filed by claimant's attorney. Deviation from the overutilization rules raises the question

of whether jurisdiction normally vested in the Division of Workers' Compensation is hereby transferred to the JCC. If so, overutilization issues would become a two step process. First, a hearing before the JCC would determine whether the E/SA complied with overutilization rules. If not, the issues would be settled by the JCC. Otherwise the issues would be settled by the DWC. If one party has presented the overutilization issue to the DWC and another requested a hearing before the JCC dual proceedings would occur. I do not believe such was the intent of the legislature. The DWC has authority to require payment of disputed bills when overutilization procedures are not followed by the E/SA. Accordingly, I find the issues presented by this case fall under the jurisdiction of the DWC and I have no jurisdiction. The Motion to Dismiss is therefore granted.

DONE AND ORDERED at Panama City, Bay County, Florida this 8th, day of December, 1993.

[SEAL]

/s/ C. Douglas Brown
C. DOUGLAS BROWN
Judge of Compensation Claims

[SEAL]

FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY

OFFICE OF THE JUDGE OF COMPENSATION CLAIMS
DISTRICT A-CENTRAL

C. DOUGLAS BROWN
Judge of Compensation Claims

September 14, 1993

Tari Rossitto-Van Winkle, Esquire
254 East Sixth Avenue
Tallahassee, FL 32303

Gregory B. Lower, Esquire
1700 American Heritage Life Building
76 South Laura Street
Jacksonville, FL 32202

Re: EMPLOYEE: Edison Furtick
EMPLOYER: William Shults Contractor
CLAIM NO: 267-88-8230
D/A: 01/10/85

I have reviewed the evidence and legal memoranda in the above case.

As this is not a constitutional court I have no authority to decide the issue of *in personam* jurisdiction over Dr. Phillips under the minimum contacts standard.

Claimant argues Dr. Phillips is not a "physician" as defined in the statute because he is not licensed by the State of Florida. As a result, he should not be subject to the overutilization review process. Addressing only the definitions in the statute that argument is technically correct. I am persuaded, however, that an out of state physician who accepts the benefit of payment under the Florida Workers Compensation law must be subject to some

control. Aside from the questions discussed below, I would find jurisdiction is in the Division of Workers Compensation rather than Judge of Compensation Claims to resolve the overutilization dispute.

Before entering an order I would like further input from each of you. Claimant argues the E/SA did not comply with the overutilization procedures as in *Wolk v. Jaylen Homes, Inc.*, 593 S. 2nd 1058 (Florida 1st DCA 1992). In that case the facts are difficult to sort out from the written opinion; however, the court states the chiropractor was deauthorized based on overutilization. The court does not delineate how the E/C in *Wolk* failed to comply with the overutilization procedure. In this case the SA has consistently contended Dr. Phillips remains authorized and the only issue is disallowance of treatment lacking medical necessity. Claimant's supplemental memorandum states "the employer/carrier has also not complied with the overutilization review process" and refers the court to the deposition of Amy Goodbread along with the Florida Workers Compensation Reimbursement Manual. My review of the underlying facts in evidence shows Dr. Phillips was notified by Maximum Medical, Inc. in the spring and summer of 1992 that the overutilization review was underway. He was then provided a copy of the reviewing physicians report and told to respond within 60 days if he disagreed. I can find no evidence of a response by Dr. Phillips. Is any further action required by the E/SA if the treating physician fails to respond within 60 days? Claimant is requested to advise the particulars of how the E/SA failed to comply with overutilization procedures. If claimant can show the E/SA failed to follow the overutilization procedures described in the rules and statutes I agree *Wolk* would control. Conversely, the *Carswell* and *Lamounette* decisions cited in *Wolk* would control if the E/SA correctly followed the overutilization review procedures. Another question is why the SA is conducting an addendum review in 1993. Is that to deal with treat-

ment rendered after the 1992 review or is it evidence the 1992 review was procedurally incomplete?

Kindly submit supplemental memorandum by September 30, 1993, limited to the issue of whether the SA did or did not comply with the overutilization procedures set forth in the rules and statute. This contemplates a single memorandum from each of you without getting into reply memorandums.

Upon receipt of the supplemental memorandums I will enter an order.

Very truly yours,

/s/ C. Douglas Brown
C. DOUGLAS BROWN
Judge of Compensation Claims

APPENDIX D

[Filed 11 Apr 1996]

SUPREME COURT OF FLORIDA

MONDAY, APRIL 8, 1996

Case No. 87,234

District Court of Appeal,
1st District—No. 94-51

EDISON M. FURTICK, JR.,
Petitioner,

v.

WILLIAM SHULTS, etc., *et al.*,
Respondents.

This cause having heretofore been submitted to the Court on jurisdictional briefs and portions of the record deemed necessary to reflect jurisdiction under Article V, Section 3(b), Florida Constitution (1980), and the Court having determined that it should decline to accept jurisdiction, it is ordered that the Petition for Review is denied.

No Motion for Rehearing will be entertained by the Court. See Fla. R. App. P. 9.330(d).

GRIMES, C.J., OVERTON, SHAW, WELLS, and ANSTEAD, JJ., concur

A True Copy

TEST:

/s/ Sid J. White
SID J. WHITE
Clerk, Supreme Court

[SEAL]

APPENDIX E

CONSTITUTIONAL PROVISIONS

FOURTEENTH AMENDMENT TO THE UNITED STATES CONSTITUTION

ARTICLE XIV

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Section 2. Representatives shall be apportioned among the several States according to their respective numbers, counting the whole number of persons in each State, excluding Indians not taxed. But when the right to vote at any election for the choice of electors for President and Vice President of the United States, Representatives in Congress, the Executive and Judicial officers of a State, or the members of the Legislature thereof, is denied to any of the male inhabitants of such State, being twenty-one years of age, and citizens of the Untied States, or in any way abridged, except for participation in rebellion, or other crime, the basis of representation therein shall be reduced in the proportion which the number of such male citizens shall bear to the whole number of male citizens twenty-one years of age in such State.

Section 3: No person shall be a Senator or Representative in Congress, or elector of President and Vice President, or hold any office, civil or military, under the United States, or under any State, who, having previously taken an oath, as a member of Congress, or as an officer of the United States, or as a member of any State legis-

lature, or as an executive or judicial officer or any State, to support the Constitution of the United States, shall have engaged in insurrection or rebellion against the same, or given aid or comfort to the enemies thereof. But Congress may by a vote of two-thirds of each House, remove such disability.

Section 4. The validity of the public debt of the United States, authorized by law, including debts incurred for payment of pensions and bounties for services in suppressing insurrection or rebellion, shall not be quesitoned. But neither the United States nor any State shall assume or pay any debt or obligation incurred in aid of insurrection or rebellion against the United States, or any claim for the loss or emancipation of any slave; but all such debts, obligations and claims shall be held illegal and void.

Section 5. The Congress shall have power to enforce, by appropriate legislation, the provisions of this article.

APPENDIX F

STATUTORY PROVISIONS

FLORIDA STATUTES

§ 48.193. Acts subjecting person to jurisdiction of courts of state

(1) Any person, whether or not a citizen or resident of this state, who personally or through an agent does any of the acts enumerated in this subsection thereby submits himself and, if he is a natural person, his personal representative to the jurisdiction of the courts of this state for any cause of action from the doing of any of the following acts:

(a) Operating, conducting, engaging in, or carrying on a business or business venture in this state or having an office or agency in this state.

(b) Committing a tortious act within this state.

(c) Owning, using, possessing, or holding a mortgage or other lien on any real property within this state.

(d) Contracting to insure any person, property, or risk located within this state at the time of contracting.

(e) With respect to a proceeding for alimony, child support, or division of property in connection with an action to dissolve a marriage or with respect to an independent action for support of dependents, maintaining a matrimonial domicile in this state at the time of the commencement of this action or, if the defendant resided in this state preceding the commencement of the action, whether cohabiting during that time or not. This paragraph does not change the residency requirement for filing an action for dissolution of marriage.

(f) Causing injury to persons or property within this state arising out of an act or omission by the defendnat outside this state, at or about the time of the injury, either:

1. The defendant was engaged in solicitation or service activities within this state; or

2. Products, materials, or things processed, serviced, or manufactured by the defendant anywhere where used or consumed within this state in the ordinary course of commerce, trade, or use.

(g) Breaching a contract in this state by failing to perform acts required by the contract to be performed in this state.

(h) With respect to a proceeding for paternity, engaging in the act of sexual intercourse within this state with respect to which a child may have been conceived.

(2) A defendant who is engaged in substantial and not isolated activity within this state, whether such activity is wholly interstate, intrastate, or otherwise, is subject to the jurisdiction of the courts of this state, whether or not the claim arises from that activity.

(3) Service of process upon any person who is subject to the jurisdiction of the courts of this state as provided in this section may be made by personally serving the process upon the defendant outside this state, as provided in s. 48.194. The service shall have the same effect as if it had been personally served within htis state.

(4) If a defendant in his pleadings demands affirmative relief on causes of action unrelated to the transaction forming the basis of the plaintiff relief on causes of action unrelated to the transaction forming the basis of the plaintiff's claim, the defendant shall thereafter in that action be subject to the jurisdiction of the court for any cause of action, regardless of its basis, which the plaintiff may by amendment assert against the defendant.

(5) Nothing contained in this section limits or affects the right to serve any process in any other manner now or hereinafter provided by law.

§ 440.13 Medical Services and Supplies; Penalty for Violations; Limitations

(1) As used in this section, the term:

(a) "Health care facility" means any hospital licensed under Chapter 395 and any health care institution licensed under Chapter 400.

(b) "Health care provider" means a physician or any recognized practitioner who provides skilled services pursuant to the prescription of or under the supervision or direction of a physician.

(c) "Independent medical examination" means an objective medical or chiropractic evaluation of the injured employee's medical condition and work status.

(d) "Medically necessary" means any service or supply used to identify or treat an illness or injury which is appropriate to the patient's diagnosis, consistent with the location of service and with the level of care provided. The service should be widely accepted by the practicing peer group, should be based on scientific criteria, and should be determined ot be reasonably safe. The service may not be of an experimental, invesitgative, or research nature, except in those instances in which prior approval of the Division has been obtained. The Division shall promulgate rules providing for such approval on a case-by-case basis when the procedure is shown to have significant benefits to the recovery and well-being of the patient.

(e) "Medicines" means drugs prescribed by an authorized health care provider and includes only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes or

states that the brand name as defined in s. 465.025 is medically necessary.

(f) "Peer review" means an evaluation by a peer review committee, after utilization review, of the appropriateness, quality, and cost of health care and health services provided a patient, based on medically accepted standards.

(g) "Peer review committee" means a committee composed of physicians licensed under the same authority as the physician who rendered the services being reviewed.

(h) "Physician" means a physician licensed under Chapter 458, an osteopath licensed under Chapter 459, a chiropractor licensed under Chapter 460, a podiatrist licensed under Chapter 461, an optometrist licensed under Chapter 463, or a dentist licensed under Chapter 466.

(i) "Utilization review" means the evaluation of appropriateness in terms of both the level and the quality of health care and health services provided a patient, based on medically accepted standards. Such evaluation shall be accomplished by means of a system which identifies the utilization of medical services, based on medically accepted standards, and which refers instances of possible inappropriate utilization to the Division for referral to a peer review committee or to obtain opinions and recommendations of expert medical consultants, with similar qualifications as those providing the care under review, recommended by the Division and approved by the three-member panel referred to in paragraph (4)(a) to review individual cases for which administrative action may be deemed necessary. Utilization review also includes reviewing cases where medical costs exceed $20,000, reviewing requests for

sequential health care by different medical care providers, and reviewing disputes between health care providers and reimbursement sources concerning interpretation of the schedules of maximum reimbursement allowances and coding procedures under said allowances.

(2) (a) Subject to the limitations specified in s. 440.19 (1)(b), the employer shall furnish to the employee such medically necessary remedial treatment, care, and attendance by a health care provider and for such period as the nature of the injury or the process of recovery may require, including medicines, medical supplies, durable medical equipment, orthoses, prostheses, and other medically necessary apparatus. However, no health care provider may refer the employee to another health care provider, diagnostic facility, pain program, work hardening program, therapy center, or other facility without the prior authorization from the carrier or the employer if self-insured, except in cases where emergency care is required.

(b) The right to conduct an independent medical examination includes, but is not limited to, instances when the authorized treating physician has not provided current medical reports; determining whether overutilization by a health care provider has occurred; whether a change in health care provider is necessary; or whether treatment is necessary or the employee appears not to be making appropriate progress in recuperation. The employer or carrier has the right to schedule an independent medical examination with a health care provider of its choice, at a reasonable time to assist in determining this status. The health care provider performing the independent medical examination shall not be

the health care provider to provide the treatment or follow-up care, unless the carrier or self-insurer and the employee so agree or unless an emergency exists.

(c) Overutilization review shall be by physicians licensed under the same licensing chapter as the physician reviewed. Overutilization of health care shall be a basis for deauthorizing such care without order of the judge of compensation claims, provided a determination has been made as provided in this section and alternate medical care has been offered by the employer or carrier. Findings of overutilization as provided in this seciton shall presumptively establish, in the absence of substantial and compelling evidence to the contrary, that such treatment is not in the best interest of the injured employee. A physician shall be barred from payment under this chapter for treatment of injured employees upon three findings of overutilization. Any list of health care providers developed by a carrier, not including pharmacists, from which health care providers are selected to provide remedial treatment, care, and attendance shall include representation of each type of health care provider defined in s. 440.13 (3)(d)1.d., Florida Statutes, 1981, and shall not discriminate against any of the types of health care providers as a class.

(d) If the employer fails to provide such treatment, care, and attendance after request by the injured employee, the employee may do so at the expense of the employer, the reasonableness and the necessity to be approved by a judge of compensation claims. The employee shall not be entitled to recover any amount personally expended for such treatment or service un-

less he or she has requested the employer to furnish the same and the employer has failed, refused, or neglected to do so or unless the nature of the injury required such treatment, nursing, and services and the employer or the superintendent or foreman thereof, having knowledge of such injury, has neglected to provide the same. Nor shall any claim for medical, surgical, or other remedial treatment be valid and enforceable unless within 14 days following the first treatment, except in cases where first-aid only is rendered, within 14 days following the date of maximum medical improvement or the date of final treatment, and at such intervals as the Division by regulation may prescribe, the health care provider or health care facility giving such treatment or treatments furnishes to the employer, or to the carrier if the employer is not self-insured, a report of such injury and treatment on forms prescribed by the Division; however, a judge of compensation claims, for good cause, may excuse the failure of the health care provider or health care facility to furnish any report within the period prescribed and may order the payment to such employee of such remuneration for treatment or service rendered as the judge of compensation claims finds equitable. Along with such reports, the health care provider shall furnish a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained. The sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing; that the facts alleged are true, to the best of my knowledge and belief; and that the treatment and

services rendered were reasonable and necessary with respect to the bodily injury sustained." Each medical bill obtained or received by the employer, the carrier, or the injured employee, or the attorney for any of them, with respect to the remedial treatment, care, and attendance of the injured employee, including any medical bill for an examination, diagnosis, or disability evaluation, shall be filed with the Division of Workers' Compensation by a deadline specified by the Division and pursuant to rules adopted by the Division.

(e) The health care provider or health care facility shall also furnish to the injured employee, or to his or her attorney, on demand, a copy of his or her office chart, records, and reports and may charge the injured employee an amount authorized by the Division for the copies. The health care provider or health care facility shall also provide to the Division such additional information with respect to the remedial treatment, care, and attendance that the Division may reasonably request as part of its investigation of a claim filed by an injured worker for benefits under this chapter. Such additional information provided to the Division by the health care provider or health care facility is confidential and exempt from the provisions of s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(f) Notwithstanding the limitations in s. 455.241 and subject ot the limitations in s. 381.004, upon the request of the employer, the carrier, the attorney for either of them, or the rehabilitation provider, the medical records of an in-

jured employee shall be furnished to such persons and the medical condition of the injured employee shall be discussed with such persons, provided the records and the discussions are restricted to conditions relating to the workplace injury or to situations where the employer or carrier has reason to believe there is a probable basis for filing a claim against the Special Disability Trust Fund as a result of such injury and the employee or his or her attorney has been furnished a copy of such claim. Medical records so provided or discussions held pursuant to this paragraph, and any information contained therein, are confidential and exempt from the provisions of s. 119.07(1), and shall not be disclosed to any other person, nor shall the same be discoverable in any civil or criminal action. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(g) The employer shall provide appropriate professional or nonprofessional custodial care when the nature of the injury so requires and is performed at the direction and control of a physician. A physician must state that home or custodial care is necessary as a result of the accident and must describe with a reasonable degree of particularity the nature and extent of the duties to be performed. Family members may not be paid for such care unless prescribed by a physician and may only be compensated for such services which go beyond the scope of household duites performed gratuitously by a family member. "Attendant or custodial care" means care usually rendered by trained professional attendants and beyond the scope of household duties.

(h) The value of nonprofessional attendant or custodial care provided by a family member shall be determined as follows:

1. If the family member is not employed, the per hour value shall be that of the federal minimum wage.

2. If the family member is employed and elects to leave that employment to provide attendant or custodial care, the per hour value of that care shall be at the per hour value of such family member's employment, not to exceed the per hour value of such care available in the community at large. In no event shall a family member or a combination of family members providing nonprofessional attendant or custodial care pursuant to this paragraph be compensated for more than a total of 12 hours per day.

"Family member" is defined for purposes of this subsection to be a spouse, father, mother, brother, sister, child, grandchild, father-in-law, mother-in-law, aunt, or uncle.

(i) The Division shall adopt rules governing the manner, means, and requirements for uitlization review by all carriers and self-insurers. The Division shall also define the procedures to be followed by carriers and self-insurers who identify cases of overutilization or improper utilization. Failure to implement utilization review procedures by a carrier or self-insurer shall be grounds for certification to the Department of Insurance. The Division shall also review utilization review procedures and findings during carrier practice audits to ensure that carriers and self-insurers have adequate utilization review programs and that such programs are actively implemented.

(j) 1. The Division shall conduct individual claimant reviews and random sample reviews of health care providers and shall also resolve reimbursement disputes based on criteria to be established by rule. Upon receipt of a request for an individual claimant review based on a charge of overutilization or improper utilization, the Division shall respond to the requesting party within 30 days. The response shall advise that either the Division finds there is no basis for the requesting party's charge, or that the Division has forwarded the request for review to the peer review committee and the Division's medical consultant. If the peer review committee and medical consultant disagree, the Division shall refer the review request to a second medical consultant. The two opinions in agreement shall determine the disposition of the review request.

2. Upon receipt of a request to resolve a reimbursement dispute, the Division shall provide to the requesting party, the employer, and the carrier, within 60 days, a written determination of whether the employer or carrier properly complied with the reimbursement policies of this chapter and the applicable schedule of maximum reimbursement allowances.

3. a. If there is disagreement in the opinions of the health care providers, if two health care providers have determined that there is no medical evidence to support the claimant's complaints or the need for additional medical treatment, or if two health care providers agree that

the employee is able to return to work, then within 15 days after receipt of the written request of the injured employee, employer, or the carrier, the judge of compensation claims shall order the injured employee to be evaluated by an appropriate health care provider from a list provided by the Division. The opinion of the health care provider shall be presumed correct unless there is clear and convincing evidence to the contrary as determined by the judge of compensation claims. The medical issues in the evaluaiton may include the following: whether the injured employee is able to perform any gainful employment temporarily or permanently; what physical restrictions, if any, would be imposed on the employee's employment; whether the injured employee has reached maximum medical improvement; the existence and extent of any permanent physical impairment; and the reasonableness and necessity of any medical treatment previously provided, or to be provided, to the injured employee. The health care provider appointed to conduct the evaluation shall have free and complete access ot the medical records of the employee. All indemnity benefits shall terminate during any period in which an employee fails to report to and cooperate with such evaluation.

b. There shall not be monetary liability on the part of, and no cause of action for damages shall arise against, a health care provider rendering an evaluation

under this subsection, without a showing of fraud or malice.

c. Upon the completion of the evaluation by the health care provider, a report shall be sent to the judge of compensation claims within 30 days after the order appointing the health care provider. A copy of the report shall also be furnished to the carrier, self-insurer, or employer, if self-insured. For the purpose of determining entitlement to attorney's fees pursuant to s. 440.34, receipt of notice of the claims' shall begin to run upon receipt of the medical report submitted by the evaluating health care provider, by the carrier, or by the employer, if self-insured.

(k) An employer, carrier, self-insurer, health care provider, or rehabilitaiton provider shall not refer, for medical care, rehabilitation, or other services under this chapter, an injured worker to any entity in which the employer, carrier, self-insurer, health care provider, or rehabilitation provider has a financial or ownership interest without disclosing to the employer and the employee in writing the nature of such interest prior to the referral.

(l) Any health care provider who gives a deposition shall be allowed a witness fee. The amount charged by such witness may not exceed $200. This limitation does not apply to an expert witness who has never provided direct professional services to a party or has provided only direct professional services which were unrelated to the workers' compensation case.

(3) If an injured employee objects to the medical attendance furnished by the employer pursuant to subsec-

tion (2), it shall be the duty of the employer to select another physician to treat the injured employee unless a judge of compensation claims determines that a change in medical attendance is not for the best interests of the injured employee; however, a judge of compensation claims may at any time, for good cause shown, in the judge of compensation claims' discretion, order a change in such remedial attention, care, or attendance. It is unlawful for any employer or representative of any insurance company or insurer to coerce or attempt to coerce a sick or injured employee in the selection of a physician, surgeon, or other attendant or remedial treatment, nursing or hospital care, or any other service that the sick or injured employee may require; and any employer or representative of any insurance company or insurer who violates this provision is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. The health care provider or health care facility providing services pursuant to this section shall be paid for the services solely by the employer or its insurance carrier, except for payments from third parties who have been determined to be liable for such payment. Subject to the provisions of paragraph (2)(d), the employee is not liable for payment for treatment or services provided pursuant to this section.

[1](4) (a) A three-member panel is created, consisting of the Insurance Commissioner and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall annually determine schedules of maximum reimbursement al-

lowances for such medically necessary remedial treatment, care, and attendance. On or before January 1, 1991, the three-member panel shall adopt a schedule of maximum reimbursement allowances for physician charges, which shall provide that maximum reimbursement allowances shall not exceed 95 percent of the 50th percentile of the physician charges used to establish the 1988 Schedule of Maximum Reimbursement. The maximum reimbursement allowances of such schedule shall not be increased for at least 2 years following adoption. Subsequent schedules of maximum reimbursement for physician charges shall not exceed 95 percent of the 50th percentile of physician charges entered into the Division's data base of medical charge data. An individual health care provider or physician shall be reimbursed either his or her usual and customary charge for treatment, care, and attendance or the maximum reimbursement allowance in the schedule, whichever is less.

(b) The three-member panel shall adopt a schedule of maximum reimbursement allowances for ambulatory surgical center charges pursuant to the following:

1. All ambulatory surgical centers shall submit data to the Division on a form and in a manner prescribed by the Division. The Division shall enter such data into its data base of medical charge data.

2. The Division shall identify those ambulatory surgical center charges which constitute 80 percent of the most frequently incurred charges, which shall be contained in the schedule of maximum reimbursement allowances for ambulatory surgical centers.

3. The Division shall prepare arrays of ambulatory surgical center charges to be included in the schedule and shall identify the values for the 50th percentile.

4. The Division shall submit the arrays to the three-member panel no later than March 1, 1991, and by March 1 of each subsequent year. The three-member panel shall review the arrays within 30 days of receipt and shall approve a schedule of maximum reimbursement allowances based on 80 percent of the 50th percentile, which will be effective July 1, 1991, and July 1 of each subsequent year.

5. Effective July 1, 1991, if the usual and customary charge is equal to or less than 80 percent of the 50th percentile, the reimbursement of the 50th percentile or 80 percent of the usual and customary charge, whichever is less. If the usual and customary charge is greater than the amount requested by 80 percent of the 50th percentile, charges shall be reimbursed at 80 percent of the 50th percentile or 65 percent of the usual and customary charge, whichever is greater. Reimbursement of a compensable ambulatory surgical center charge not itemized in the schedule of maximum reimbursement allowance shall be at 70 percent of the ambulatory surgical center's usual and customary charge. Until the three-member panel approves a schedule of maximum reimbursement allowances, all medically necessary compensable ambulatory surgical center charges shall be reimbursed at 80 percent of their usual and customary charge.

(c) No later than August 1, 1990, all hospitals shall submit to the Division the price list masters which were in effect on January 1, 1990. The Division shall review a random sample of hospital charges received in order to determine at least 250 of the most frequently incurred hospital charges for treatment of injured employees pursuant to this chapter. The Division shall prepare arrays of hospital charges from the price list masters for at least 250 of the most frequently incurred charges and shall identify the values for the 50th percentile. The Division shall submit the arrays to the three-member panel no later than October 1, 1990. The three-member panel shall review the arrays within 30 days of receipt and shall approve a schedule of maximum reimbursement allowances based on 80 percent of the 50th percentile, which will be effective January 1, 1991. Effective January 1, 1991, if the usual and customary charge is equal to or less than 80 percent of the 50th percentile, the reimbursement shall be at 80 percent of the 50th percentile or 80 percent of the usual and customary charges, whichever is less. If the usual and customary charge is greater than the amount represented by 80 percent of the 50th percentile, charges shall be reimbursed at 80 percent of the 50th percentile or 65 percent of the usual and customary charge, whichever is greater. Reimbursement of a compensable hospital charge not itemized in the schedule of maximum reimbursement allowances shall be at 70 percent of the hospital's usual and customary charge.

Notwithstanding the above, compensable charges for trauma centers, as defined in s. 395.401, and for emergency services and care, as defined in s. 395.002, shall

be reimbursed at 80 percent of the usual and customary charge from July 1, 1990, through December 31, 1991. Effective January 1, 1992, the schedule of maximum reimbursement allowances shall include at least 250 of the most frequently incurred charges for hospitals, emergency services and care, and trauma centers. Effective January 1, 1992, reimbursement of compensable charges for emergency services and care and trauma centers not itemized in the schedule of maximum reimbursement allowances shall be at 70 percent of the usual and customary charge. Until the three-member panel approves a schedule of maximum reimbursement allowances and it becomes effective, all medically necessary compensable hospital charges shall be reimbursed at 75 percent of their usual and customary charge. The Division shall develop a data base of at least 250 of the most frequently incurred charges for hospitals, emergency maximum reimbursement allowances. Beginning July 1, 1991, and on an annual basis thereafter, the Division shall develop arrays of at least 250 of the most frequently incurred charges contained in the schedule of maximum reimbursement allowances from charge data entered into the Division's data base for the previous year, which shall include charge data for hospitals, trauma centers, and emergency services and care. The Division shall enter the charge data into its data base of medical charge data to ensure accurate arrays. The three-member panel shall annually review the data arrays and shall approve a schedule of maximum reimbursement allowances based on a maximum of 80 percent of the 50th percentile, which shall not reflect an increase greater than the aggregate maximum allowable rate of increase as defined in s. 408.07, and which shall become effective the subsequent January 1. The three-member panel may develop two or more schedules of maximum reimbursement allowances based on groupings of hospitals providing like services. However, the maximum reimbursement allowances contained in the schedule of maximum reimburse-

ment allowances for each group shall not exceed 80 percent of the 50th percentile of that group. Actual reimbursement of charges shall be as otherwise provided in this section.

(d) The three-member panel shall adopt a schedule of maximum reimbursement allowances for work hardening program charges and pain program charges pursuant to the following:

1. All work hardening centers and pain programs shall submit charge data to the Division on a form and in a manner prescribed by the Division. The Division shall enter such data into its data base of medical charge data and identify those charges which constitute 80 percent of the most frequently incurred charges.

2. The Division shall prepare arrays of the charge data for the most frequently incurred charges and submit them to the three-member panel no later than August 1, 1991. The three-member panel shall review the arrays within 30 days of receipt and shall approve a schedule of maximum reimbursement allowances, which is reasonable and which provides for cost containment. Work hardening center charges and pain program charges shall be reimbursed at either the usual and customary charge or the maximum reimbursement allowance in the schedule, whichever is less.

3. The schedule of maximum reimbursement for work hardening centers and pain programs shall be effective no later than January 1, 1992. Reimbursement of a compensable charge not specifically itemized in the applicable schedule shall be at 70 per-

cent of the usual and customary charge. Until the three-member panel adopts a schedule of maximum reimbursement allowances for pain programs and work hardening centers, all medically necessary charges for pain programs and work hardening centers shall be at 80 percent of the usual and customary charge.

(e) As to reimbursements for prescription medication, the maximum reimbursment amount for a prescription shall be the average wholesale price times 1.2 plus $4.18 for the dispensing fee.

(f) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, shall not exceed the amounts provided by the schedules of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. In determining the schedules, the panel shall first approve the bodies of medical and hospital data which it finds representative of prevailing charges in the state for such treatment, care, and attendance in the state for similar treatment, care, and attendance of injured persons. In determining the schedule for hospitals after January 1, 1987, the panel shall approve and use charge data submitted by hospitals to the Division and to the Health Care Cost Containment Board, where applicable, as representative of charges for the treatment, care, and attendance in the state of injured persons. Each health care provider, health care facility, ambulatory surgical center, hospital, pain program, or work hardening center receiving workers'

compensation payments shall maintain records verifying their usual charges. In establishing the schedules of maximum reimbursement allowances, the panel shall consider the following:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;

2. a. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance, which will ensure the availability of treatment, care, and attendance required by injured workers; and

   b. The potential change in workers' compensation insurance premiums or costs attributable to the level of treatment, care, and attendance provided; and

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The schedules of maximum reimbursement allowances shall be reasonable, shall promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and shall be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers.

(g) Definitions, policies, and procedures contained in the 1988 Edition of the Florida Workers' Compensation Reimbursement Manual and not revised, amended, or otherwise addressed by

this act, shall remain in effect until a subsequent edition is promulgated by the Division.

(h) The Division of Workers' Compensation of the Department of Labor and Employment Security is empowered to investigate health care providers and health care facilities to determine if they are in compliance with the rules adopted by the Division or department or if they are requiring unjustified treatment, hospitalization, or office visits. If the Division finds that a health care provider or health care facility has made such excessive charges or required such treatment, services, hospitalization, or visits, the health care provider or health care facility may not receive payment under this chapter from a carrier, employer, or employee for the excessive fees or unjustified treatment, hospitalization, or visits; furthermore, the health care provider or health care facility is liable to return to the carrier or self-insurer any such fees or charges already collected.

(i) 1. The Division shall develop and implement, or contract, with a qualified entity to develop and implement, utilization review of the services rendered by a health care provider or a physician, which services are paid for in whole or in part pursuant to this chapter. Utilization review shall be accomplished either by request from any interested party or upon the request of the Division. Findings of overutilization shall include deauthorization of the care under review or denial of payment for services rendered in the future, or both. During the utilization review process, the care under review shall continue. Utilization review under this section shall be exempt from the provisions of Chapter 120.

2. The Division shall contract with a private nonprofit foundation or nonprofit organization to provide peer review or utilization review, as appropriate, of health care and physician services rendered pursuant to this chapter. Under the terms of such contract, the foundation or organization shall establish and maintain a procedure by which a peer review committee shall review the services rendered by a health care provider, physician, or health care facility, which services are paid for in whole or in part pursuant to this chapter. Such review shall occur upon a determination by the Division that information referred to it by the entity responsible for utilization review contains reliable information that a health care provider or health care facility is rendering services in a manner which may be inappropriate with respect to either the level or the quality of care. The report and recommendations of the peer review committee shall be submitted to the Division for such action as may be necessary in accordance with this section.

3. By accepting payment pursuant to this chapter for remedial treatment rendered to an injured employee, a health care provider or health care facility shall be deemed to consent to submitting all necessary records and other information concerning such treatment to utilization review and peer review as provided by this section. Such health care provider shall further agree to comply with any decision of the Division pursuant to subparagraph 4.

4. If it is determined that a physician improperly overutilized, or otherwise rendered or

ordered inappropriate medical treatment or services, or that the reimbursement for such treatment or services was inappropriate, the Division may order the phyhician to show cause why he or she should not be required to repay the amount which was paid for the rendering or ordering of such treatment or services and shall inform him or her of his or her right to a hearing under the provisions of s. 120.57. If a hearing is not requested within 30 days of receipt of the order and the Division director decides to proceed with the matter, a hearing shall be conducted, a prima facie case established, and a final order issued. If the final order, including judicial review if the order is appealed, is adverse to the physician, the Division shall provide the licensing board of the physician with full documentation of such determination.

5. A health care facility may not improperly charge or overcharge a workers' compensation insurer or charge for services not provided for the purpose of obtaining additional reimbursement.

6. Violations of this section which are willful or which demonstrate a pattern of improperly charging or overcharging workers' compensation insurers constitute grounds for the Division or department to impose a fine not to exceed $5,000.

7. The referral by the entity responsible for the utilization review, the decision of the Division to refer the matter to the peer review committee, the establishment by the foundation or organization of the procedures by which a peer review committee re-

views the rendering of health care services, and the review proceedings, report, and recommendation of the peer review committee are not subject to the provisions of Chapter 120.

8. The provisions of s. 766.101 apply to any officer, employee, or agent of the Division and to any officer, employee, or agent of any entity with which the Division has contracted pursuant to this section.

(5) The Division shall audit employers, carriers, and self-insurers to determine if medical bills are paid in accordance with s. 440.13 and Division rules. Any employer, carrier, or self-insurer found by the Division not to be within 90 percent compliance as to the payment of medical bills shall be assessed a fine of $50 per incorrect bill. Within 60 days of the first audit, the Division shall conduct a second audit for any employer found not to be in compliance, and if the employer is still not within 90 percent compliance, the Division shall assess the employer $100 per incorrect bill. Any employer found not in compliance by the second audit shall be required to implement a medical bill review program approved by the Division, and shall be subject to appropriate licensing review by either the Division or the Department of Insurance.

(6) An injured employee is entitled, as a part of his or her remedial treatment, care, and attendance, to reasonable actual cost of transportation to and from the doctor's office, hospital, or other place of treatment by the most economical means of transportation available and suitable in the individual case. When the employee is entitled to such reimbursement for transportation by private automobile, it shall be presumed, in the absence of proof, that the actual cost

is the amount allowed by the state to employees for official travel.

[1] Note.—Section 81, ch. 92-289, purported to amend subsection (4), but did not set out in full the amended subsection to include paragraph (d)-(i). In the absence of affirmative evidence that the Legislature intended to repeal paragraphs (d)-(i) subsection (4) is set out in full here, pending clarification by further action by the Legislature.

APPENDIX G

REGULATIONS

FLORIDA ADMINISTRATIVE CODE

38F-7.507 Types of Utilization Review Performed by the Division

(1) Individual Claimant Review. A review of the medical care and services rendered to an individual claimant shall be performed when a valid utilization review request is received and:

(a) When medical care costs exceed $20,000;

(b) When there is evidence of sequential health care by different medical providers;

(c) When there is a dispute between health care providers and reimbursement sources concerning interpretations of reimbursement policies and maximum reimbursement allowances; or

(d) When a health care provider's billings indicate the possibility of improper utilization.

(2) Random Sample Review. A review of the medical care and services rendered to a random sample of claimants from a health care provider's workers' compensation practice may be performed:

(a) When a valid request for utilization review is received by the Division; or

(b) When Division reports identify providers whose practice patterns deviate significantly from average peer practice patterns.

Specific Authority 120.53, F.S., 440.591, F.S. Law Implemented 440.13(1)(i), 4(h), (i), 440.13(2)(i), F.S. History—New 4-17-90, Amended 1-13-92.

38F-7.509 Access to Medical Records

In accordance with s. 440.13(2)(c), F.S., by accepting payment for remedial treatment rendered to an ill or injured employee, a provider is deemed to consent to submitting to utilization review and peer review of all requested medical records and other information pertaining to the medical services rendered.

Specific Authority 120.53, F.S., 440-591, F.S. Law Implemented 440.13(4)(h)(i), F.S. History—New 4-17-90.

38F-7.518 Disputed Reimbursement Resolution

In those instances when a provider does not agree with a carrier's reconsidered reimbursement decision, the Division will, upon request, provide for a settlement of such reimbursement dispute through a review process conducted by the Division's Bureau of Medical Services and Rehabilitation.

(1) The provider, the carrier, or the employer may request a resolution to a reimbursement dispute from the Division. A valid Request for Resolution of Disputed Reimbursement must:

(a) Be in writing and specify the specific service(s) and policy being disputed.

(b) Be submitted to the Division's Bureau of Medical Services and Rehabilitation within the specified times, unless there is good cause:

1. Within 60 days from the receipt of the carrier's reconsideration determination.

2. Within 90 days from the date the reconsideration request was sent to the carrier when there has been no response from the carrier.

3. Within 45 days from receipt of the request for a reconsideration when the carrier has

obtained a physician's opinion and remains uncertain of a policy interpretation.

(c) Include copies of the following:

1. All bills submitted or resubmitted that are related to the services in question and their attachments.
2. All applicable Explanations of Medical Benefits.
3. All correspondence between the carrier and provider which is relevant to the disputed reimbursement.
4. Any notations of phone calls regarding authorization.
5. Any pertinent or required health care records or reports or carrier medical opinions.

(2) The Division's response to a valid disputed reimbursement request will:

(a) Be within 60 days of receipt.

(b) Establish the proper reimbursement amount, including over- and underpayments.

(c) Identify the basis for the decision.

(d) Be sent to the provider, carrier, and employer.

(e) Be in writing.

(f) Provide for reconsiderations through physicians and peer review before an appeal pursuant to Chapter 120.57.

(3) Requests for Resolution of Disputed Reimbursement will be returned as not valid when:

(a) The required documentaiton is not included with the request.

(b) The date of the request for a reconsideration exceeds the time requirements as specified in this section.

(c) A notice of denial has been filed in accordance with Rule 38F-3.012.

(d) The dispute relates to the bill(s) not having been paid timely as specified in Rule 38F-3.006.

Specified Authority 440.591, 440.13(2)(i)1, F.S. Law Implemented 440.13(2)(a), (i) F.S. History—News 5-15-91.

APPENDIX H

RAISING OF CONSTITUTIONAL ISSUE

IN THE DISTRICT COURT OF APPEAL
FIRST DISTRICT OF FLORIDA

Case No. 94-00051

EDISON M. FURTICK, JR.,
Appellant,

v.

WILLIAM SHULTS, CONTRACTOR and
EXECUTIVE RISK CONSULTANTS, INC.,
Appellees.

INITIAL BRIEF OF APPELLANT

On Appeal from a Final Order of the
Judge of Compensation Claims

TARI ROSSITTO-VAN WINKLE
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(904) 224-3131
Florida Bar No. 0613908

Attorney for Appellant

* * * *

ARGUMENT

I. THE DIVISION OF WORKER'S COMPENSATION HAS NO JURISDICTION 0VER DR. PHILLIPS

As a preliminary matter, this Court must consider whether the agency below enjoys competent jurisdiction over Dr. Phillips, a South Carolina resident. The State of Florida can exercise *in personam* jurisdiction over a foreign doctor only by satisfying a two-part test. *See Georgia Insurers Insol. Pool v. Brewer,* 602 So. 2d 1264, 1266, 1268 (Fla. 1992); *AVH Daily Rental Cars, Inc. v. Smith,* 1994 WL 391332 *1 (Fla. 1st DCA, July 29, 1994). First, one must determine whether jurisdiction exists under Florida's long-arm statute. § 48.193, Fla. Stat. (1993). Second, one must demonstrate the existence of "minimum contacts" with the State of Florida. *Brewer,* 602 So. 2d at 1268; *Venetian Salami Co. v. Parthenais,* 554 So. 2d 499 (Fla. 1989). As will be seen, this second step is itself a two-part inquiry, requiring further that one consider whether the maintenance of the action "offend[s] 'traditional notions of fair play and substantial justice.'" *Brewer,* 602 So. 2d at 1268 (quoting *International Shoe Co. v. Washington,* 326 U.S. 310, 316 (1945)). Appellees fall flat at each of these hurdles.

A. Florida's Long-Arm Statute Does Not Reach Dr. Phillips

First, it is clear that by treating a South Carolina resident in South Carolina, Dr. Phillips has in no way "submit[ted] himself . . . to the jurisdiction" of Florida's agencies. § 48.193(1), Fla. Stat. (1993). Dr. Phillips has not committed any of the enumerated acts in Section 48.193(1) to come within the fold of Florida's long-arm statute. *See American Community Mut. Ins. v. Naples Research & Counseling Center, Inc.,* 534 So. 2d 836

(Fla. 2d DCA 1988) (holding that section 48.913(1)(g), extending jurisdiction to any person who breaches a contract in the state, would not allow a Florida medical provider to sue a Michigan insurance company on a policy written for Michigan residents). The long-arm statute simply does not apply.

B. Dr. Phillips Does Not Have Minimum Contacts with Florida

Second, even if one used a strained reading of Section 48.193(1), and found that Dr. Phillips "submit[ted] himself" to agency jurisdiction, he still does not have the requisite "minimum contacts" with Florida. The minimum contacts inquiry involves, as its central focus, an examination of "the relationship among the defendant, the forum, and the litigation." *Brewer*, 602 So. 2d at 1267 (quoting *Shaffer v. Heitner*, 433 U.S. 186, 204 (1977)). On this score, Appellant notes the following critical facts: Dr. Phillips is not licensed in Florida, does not do business in Florida, had no offices in Florida, and owned no real or personal property in Florida. Further, the medical treatment was contracted for, and provided in, South Carolina to a South Carolina resident. Payment was due in South Carolina. Dr. Phillips did not solicit the business of injured Florida workers, or even workers injured in Florida.

The only plausible connection Dr. Phillips has with the State of Florida is through Appellant Edison Furtick, whose injury arose in Florida, and who later moved to South Carolina for work. But jurisdiction cannot hang on this single shoe string[8] since "[t]he unilateral activity of those who claim some relationship with a nonresident defendant cannot satisfy the requirement of contact with the forum State." *Brewer*, 602 So. 2d at 1267 (quoting

[8] *See International Stoe Co. v. Washington*, 326 U.S. 310, 319 (1945) (stating that there must be meaningful "contacts, ties, or relations" with the forum).

Hanson v. Denckla, 357 U.S. 235, 253 (1958)). Edison Furtick is not, simply by virtue of his injury on Dog Island, Florida, transformed into a roving emissary of Florida agency jurisdiction, subjecting every doctor he visits to the control of the Division.

Due process instead requires that Dr. Phillips have purposefully availed himself of Florida's privileges and protection, or have foreseeably engaged in business with the state that would bring him before the Division. *Brewer*, 602 So. 2d at 1268 (citing *Burger King Corp. v. Rudzewicz*, 471 U.S. 462 (1985)). This he did not do. With regard to foreseeability, the activities and conduct of Dr. Phillips must be such that he "should reasonably anticipate being haled into court" in Florida. *Brewer*, 602 So. 2d 1268 (quoting *World-Wide Volkswagen Corp. v. Woodson*, 444 U.S. 286 (1980)). With Dr. Phillips' patient, practice and resistence all in South Carolina, this he could not foresee.

1. Accepting Payments Does Not Subject Dr. Phillips to Department Jurisdiction

This Court may expect Appellees to make much of the statement in Section 440.13, Florida Statutes, that "[b]y accepting payment pursuant to [Chapter 440] . . . , a health care provider . . . shall be deemed to consent to submitting . . . to utilization review and peer review as provided by [Section 440.13]." § 440.13(a)(i)3., Fla. Stat. (1993) (emphasis added). To avoid any confusion, Appellant directs this Court to the use of the term "health care provider" in Section 440.13. That same section restricts the definition of a "health care provider" to "physician[s]." § 440.13(1)(b), Fla. Stat. (1993). In turn, Section 440.13 defines the term "physician" to include (among other licensed professions) only those "chiropractor[s] licensed under Chapter 560, . . ." § 440.13 (1)(h), Fla. Stat. (1993).

Now, it's clear that Dr. Phillips, although duly licensed in South Carolina, is *not* a "chiropractor licensed [in

Florida] under Chapter 560." § 440.13(1)(h), Fla. Stat. (1993). And so he is neither a "physician" nor a "health care provider" as defined in Section 440.13(1)(b). Accordingly, since Doctor Phillips is not a "health care provider" *for purposes of the section*, the 'submission' language of Section 440.13(4)(i)3., Florida Statutes (1993), does not apply.

Put another way, the Legislature did not intend to have Dr. Phillips unwittingly submit to the Department's utilization procedures simply by cashing the few checks sent by ERC. Since this much comes from a plain-language reading of the section, this Court should guard against any possible attempts by Appellees to inject ambiguity into the statute.[9] *Bush Leasing, Inc. v. Gallo*, 634 So. 2d 737, 741 (Fla. 1st DCA 1994) ("When the language of a statute is clear and unambiguous, the statute must be given its plain and ordinary meaning.")

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[9] In full candor, Appellant must inform the Court that the Department has taken a contrary approach to Section 440.13(4)(i)3., as revealed by this colloquy between counsel for Applelant and a witness from the Division:

> Q: Are they [Florida Statutes] applicable to a citizen of South Carolina?
>
> A: If that citizen of South Carolina is carrying on business with the State of Florida, yes.

(R. 28; *see also* R. 9-10). The Division evidently would apply Section 440.13(a)(i)3., Florida Statutes to "a chiropractor licensed by the same statute in another state . . . [because] [i]t's the same —same logic . . . ." (R. 28).

While ordinary, this Court owes some deference to agency constructions of their organic statutes, *General Telephone Co. of Florida v. Florida Public Service Comm'n*, 446 So. 2d 1063 (Fla. 1984), "[a] slightly different analysis takes place, however, where the jurisdiction of the agency is in question." *Cataract Surgery Center v. Health Care Cost Containment Board*, 581 So. 2d 1359, 1361 (Fla. 1st DCA 1991). Thus, since the Division's construction of Section 440.13(4)(i)3. involves agency jurisdiction, no deference is in order.

(citing *Aetna Casualty & Surety v. Huntington Nat'l Bank*, 609 So. 2d 1315, 1317 (Fla. 1992)).

Supported not only by common sense, Appellant's construction of Section 440.13(4)(i)3., also conforms to notions of due process. Constitutional minimum contacts do not arise simply from the acceptance of a check payment mailed from the forum state. It is well settled that "an individual's contract with an out-of-state party alone" will not automatically establish sufficient minimum contacts in the other party's home forum. *Burger King Corp. v. Rudzewicz*, 471 U.S. 462, 478, 105 S. Ct. 2174, 2185, 85 L. Ed. 2d 528 (1985); *Venetian Salami Co. v. Parthenais*, 554 So. 2d 499 (Fla. 1989). Similarly, the numerous mailings (and infrequent checks) sent to Dr. Phillips will not let the Division drag the doctor all the way to Florida. *See Pres-Kap, Inc. v. System One, Direct Access, Inc.*, 636 So. 2d 1351 (Fla. 3d DCA 1994) (forwarding check payments—even coupled with other contacts—are not sufficient to establish minimum contacts; no jurisdiction); *see also American Community Mut. Ins. v. Naples Research & Counseling Center, Inc.*, 534 So. 2d 836 (Fla. 2d DCA 1988).

Thus, by calling South Carolina, telling Dr. Phillips to care for Mr. Furtick, making promises of payment, and then later changing its mind, ERC did not unilaterally subject Dr. Phillips to Florida jurisdiction and Division control. Nothing in Section 440.13(4)(i)3., Florida Statutes (1993), defends such an action by ERC. And nothing in Florida's law of minimum contacts would permit such a maneuver.

C. Subjecting Dr. Phillips to Department Jurisdiction Offends Traditional Notions of Fair Play and Substantial Justice

Finally, even if one speculates that Florida's long-arm statute applies to Dr. Phillips, and imagines further that there exists sufficient minimum contacts, the Division's

exercise of jurisdiction over Dr. Phillips nonetheless simply cannot stand. Even with long-arm activity and sufficient minimum contacts, jurisdiction does not attach were it would offend traditional notions of fair play and substantial justice. *Brewer*, 602 So. 2d at 1268. The Division and ERC have both failed, utterly, to apprise Dr. Phillips of his right to contest payment reductions taken in a utilization review process. They have not provided him copies of Florida rules, or even a simple notice that these rules exist. Without such notice, it is unfair to subject Dr. Phillips to Division jurisdiction.

Now, whether jurisdiction is "unfairly" asserted and maintained raises an essentially equitable question. But consider this: it is the Department's admitted, stated policy that out-of-state doctors are *not* informed of the utilization review procedures. In all the mailings, in all the forms Florida carriers send to doctors, "[t]here is no place that providers . . . out-of-state are advised of their" rights under Florida law and agency rules. (R. 26.) So how does the Department expect out-of-state doctors to follow the constantly-shifting rules and manual? Well, "they are responsible for knowing the rules and regulations of the different payer entities that they are involved in." (R. 26) (statement of Molly Frawley, supervisor of utilization review at the Division of Worker's Compensation (*see* R. 8)). This, despite the fact that ERC never even cited to the specific, applicable rules in correspondence with Dr. Phillips.

Consider further the complete lack of notice given to out-of-state doctors, as shown in counsel's questioning of the Division's representative in charge of utilization review:

> Q: So in other words, unless they told [Dr. Phillips] during that first forty-five day period that he had sixty days to respond after that forty-five day period, they—he had no idea what he was supposed to do.
>
> A: Probably not. Unless he had read the reimbursement manual or the rules.

Q: And is there anything in your rules that require carriers to provide out-of-state physicians with copies of the reimbursement manual?

A: Not at this time.

Q: It there anything in your rules that requires carriers to provide out-of-state physicians supplying services with copies of even the rules of the Division?

A: Not at this time.

(R. 33-34.) Without providing copies of the manual, without providing copies of the rules, and *without even giving notice these materials exist*, the Division's attitude toward out-of-state doctors is best summarized by the witness: "they'd better learn the laws." (R. 34.) The Division's policy earns a sarcastic response: How can these out-of-state providers "learn the laws" if the carrier and agency don't tell them what laws they are applying?

Appellant respectfully suggests that this lack of notice "violates traditional notions of fair play and substantial justice." *Brewer*, 6042 So. 2d at 1268. Notice is the back-bone of due process. *See K.T.M. v. Department of Health & Rehabilitative Services*, 608 So. 2d 865 (Fla. 1st DCA 1992) (citing *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306 (1950)). And the failure to provide Dr. Phillips the rules of the game—or even tell him that they are available upon request—is simply not fair.

Submitting a South Carolina doctor to Division jurisdiction merely because he cashed a few small checks from a Florida carrier is wrong. Jurisdiction should be based on something more substantial that the Division's attitude towards out-of-state doctors: "they'd better learn the laws." (R. 34.) To the contrary, the Division had better learn the Constitution.

* * * *

APPENDIX I

OTHER MATERIALS

FL Workers' Compensation
1991 Provider Manual

CHAPTER 1

BASIC INFORMATION

XII. *Out-of-State Medical Services.*

A. The requirements and the MRAs of this manual are not applicable to medical services rendered outside of the State of Florida even though the services are provided under the Florida Workers' Compensation Act.

B. In accordance with s. 440.13, F.S., health care providers are required to report treatment to the employer or carrier on forms prescribed by the Division of Workers' Compensation.

1. The Division has by rule prescribed timely filing of reports on the LES Forms DWC-9, DWC-10 and DWC-11 (see Chapter 2, Health Insurance Claim Forms and Billing Guidelines).

2. The Florida Workers' Compensation Act makes no exception for out-of-state providers in regard to forms or timely filing of reports.

BEFORE THE
JUDGE OF COMPENSATION CLAIMS
DISTRICT "A-CENTRAL"

Docket No.: 94-00051

Claim No.: 267-88-8230

D/A: 1/10/85

IN RE: The Appeal of EDISON M. FURTICK, JR.,

versus

WILLIAM SHULTS, Contractor and ERC.

Before: THE HONORABLE C. DOUGLAS BROWN
Judge of Compensation Claims

Date: April 22, 1993 and July 6, 1993

[4] WHEREUPON . . . .

THE JUDGE: Today is July 6, 1993. This is a hearing in the case of Edison Furtick versus William Shults, Contractor and ERC. The claim number is 267-88-8230. The date of accident is January 10, 1985. The claimant is represented by Tari Rossitto-VanWinkle of Tallahassee. The employer/carrier is represented by Gregory Lower of Jacksonville.

We were set for final hearing today and still are. A pretrial stipulation was filed and approved. Friday of last week, or sometime last week, the employer filed a motion to dismiss claiming that this Court has no jurisdiction. It's not the first time this issue was ever mentioned. When we had a previous hearing we were advised at that time that they were taking that position and intended to assert it at some time.

They're contending that this is basically an over-utilization question and under the holding of a couple cases that the Division of Workers' Comp has exclusive jurisdiction to resolve that question and that the JCC has no jurisdiction. On the other hand, the employee has responded with a memorandum attaching certain provisions of the Workers' Compensation manual from the Division of Workers' Compensation and on page 20, in particular, paragraph XII [5] refer to out-of-state medical services and states that the requirements and the MRAs of the manual are not applicable to medical services rendered outside the State of Florida, even though the services are provided under the Florida Workers' Comp Act.

That is the basis for their contention that the Division of Workers' Comp has no jurisdiction over any utilization question involving the practitioner in Hilton Head, South Carolina.

This morning when I reviewed the file in preparation for the hearing, I had my secretary contact the Division of Workers' Compensation and determine who was in charge of that over-utilization department and ascertain workers that person would be available to testify and state the position of the Division or whether they have jurisdiction or not. We were advised that the individual in charge is Ms. Molly Frawley, F-r-a-w-l-e-y, and that she would be available and would be accompanied by the Division attorney Michael Moore.

At this time I'm going to place a call to Ms. Frawley and try to get her under oath and ask her a preliminary question and then have the attorneys conduct an examination of her as to the basis of their claim and whether they have jurisdiction or not.

(TELEPHONE CALL PLACED)

[6] MS. FRAWLEY: This is Molly Frawley. May I help you, please?

THE JUDGE: Ms. Frawley, this is Judge Brown in Panama City.

MS. FRAWLEY: Yes, sir.

THE JUDGE: I have here with me Tari Rossitto-VanWinkle, an attorney from Tallahassee that represents the claimant, Edison Furtick.

MS. FRAWLEY: Yes, sir.

THE JUDGE: And Gregory Lower, an attorney from Jacksonville, who represents the employer, William Shults Contractor. And as I understand it, you are the head of this over-utilization review department over there?

MS. FRAWLEY: Yes, sir. . . .

* * * *

[8] THE JUDGE: . . . So, Ms. Frawley, could you just raise your right hand, please?

MS. FRAWLEY: Yes, sir.

WHEREUPON . . . .

MOLLY FRAWLEY,

was called as a witness on behalf of the employer/carrier, and after being duly sworn, testified as follows:

THE JUDGE: What is your name?

THE WITNESS: Molly Frawley.

THE JUDGE: And what is your position?

THE WITNESS: I'm the supervisor of utilization review.

THE JUDGE: Okay. And that's in the Division of Workers' Compensation?

THE WITNESS: Yes, sir.

[9] THE JUDGE: Okay. We have a case pending down here, Edison Furtick versus William Shults, Contractor, and ERC in which a chiropractic physician in Hilton Head, South Carolina has rendered treatment and the self-insured servicing agent has performed a review by another chiropractor and made a decision that there is over-utilization involved and the claimant is challenging that because the doctor practices in South Carolina rather than Florida and the Workers' Comp manual, 1991 edition, paragraph XII on page 20 states that under out-of-

state medical services, the requirements and MRAs of the manual are not applicable to medical services rendered outside the State of Florida, even though the services are provided under the Florida Workers' Compensation Act.

So based upon that, the employee contends that the Division has no jurisdiction for over-utilization, just as they would have no jurisdiction to require the doctor to conform his fees to the fee schedule in effect at the time.

What is the position of your department on whether you do or do not have over-utilization jurisdiction over out-of-state practitioners?

THE WITNESS: Our position is that we have jurisdiction over all utilization matters, [10] in-state or out-of-state.

THE JUDGE: Okay. And what—what is that based upon?

THE WITNESS: It's based on 440.13(4), the utilization review component of the statute and no where in there does it exclude out-of-state providers. It does state that any provider who receives payments for services is subject to utilization review.

THE JUDGE: Okay. Ms. VanWinkle, since she's taken the position opposite to your position, why don't you go ahead and conduct your Cross-Examination at this time.

MS. ROSSITTO-VanWINKLE: Your Honor, may I have permission to treat her as a hostile witness?

THE JUDGE: Well, if you want to lead her, that's fine.

MS. ROSSITTO-VanWINKLE: And lead questions?

THE JUDGE: Go ahead. Yeah, you're on Cross anyway, as far as I'm concerned.

MS. ROSSITTO-VanWINKLE: Okay, thank you.

CROSS-EXAMINATION

BY MS. ROSSITTO-VanWINKLE:

Q Ms. Frawley?

A Yes, can you come closer to the phone, [11] please?

Q I'm sorry. Ms. Frawley, are you—do you have the Florida Workers' Compensation Provider Manual in front of you?

A Yes, I do.

Q Would you agree with me that the MRAs of this manual are not applicable to out-of-state physicians?

A According to the manual that is correct.

Q I'd like to refer you to page 20 of that manual where it specifically states that not only are the MRAs not applicable to the services rendered out of the State of Florida but also the requirements; is that correct? Is that what it states?

A It's talking about the reimbursement requirements and MRAs, that is correct.

Q The requirements—it says, the requirements and MRAs of this manual; is that correct? Is that what it says?

A That's what I read.

Q Okay. And then I'd like you to refer to page 17 in the manual at number X, number ten, Roman numeral ten where it says utilization review; do you see that?

A Uh-huh.

Q And that also says that the carrier's utilization review responsibilities and it goes through the [12] process of utilization review; is that correct?

A It goes through part of them; that's correct.

Q So if you read paragraph ten and paragraph twelve in conjunction with each other, that would mean that all those requirements in paragraph ten are not applicable to out-of-state physicians; correct?

A That's not how I would read it, no.

Q And why is that?

A Because Roman numeral nine and Roman numeral ten of the reimbursement manual are referencing other

rules more as reference because this is a manual as opposed to strictly the way rules are written and they're referencing other components. But utilization review is not a reimbursement issue. It is just mentioned in the reimbursement manual to put providers and carriers on alert that it exists.

Q So in other words, you can't—you're not permitted under this manual to dispute the amount of a physician's charge; is that correct? An out-of-state physician?

A That's correct.

Q But you are permitted to, in your opinion and in your review of this, to dispute whether he's over-treating or not.

[13] A That is correct.

Q How do you explain that then, in light of the rules which specifically at the 38(f)-7.505 which says the purpose of the Workers' Compensation reimbursement and utilization review rules are to implement section 440.13 and in that particular section at 37(f)-7.506, definitions, it defines a "health care provider" and it indicates that it's a physician or a recognized practitioner providing skilled services under the prescription of or under the supervision of a direction of a physician, defines a health care provider to include—

A There's enough cut off and your question is long enough—but I'm not following you at all.

Q All right. Let me—let me start over again. Do you have a copy of the Workers' Compensation utilization review rules in front of you; the LES rules?

A Are you talking about 38(f)-7.505?

Q Yes.

A Which rule are you talking about?

Q Let's start with 505.

A Okay, I have 505 in front of me.

Q It says the purpose of this particular—

A Correct.

Q —and these are the rules applicable to Workers' Compensation utilization review; correct?

[14] A For the Division's component; that's correct.

Q All right. And the purpose of those rules is to implement 440.13(1)(i), (2)(a) through (c), and (4)(h) through (i); is that correct?

A Okay.

Q And it specifically says by establishing the criteria and procedures which the Division follows in performing utilization review of health care providers; correct?

A Okay.

Q And then down in number 38(f)-7.506, the definition section, it defines a health care provider to include a physician; is that correct?

A Correct.

Q And then at number fourteen it defines a physician, and in our particular case here, a chiropractor, as a doctor of chiropractic, licensed under chapter 460; correct?

A Okay, correct.

Q Okay. And then it says specifically at 38(f)-7.501, where it says utilization review process, number 3 there it says reimbursement disputes will be resolved by the evaluating of the carrier's compliance with the reimbursement policies of the applicable Florida [15] Workers' Compensation Reimbursement Manual and that again would refer us back to page 20 of the manual dealing with out-of-state services. My question then to you is, since Dr. Phillips is not a chiropractor licensed under 440.61, how can it be applicable to him?

A He's a chiropractor licensed by the same statute in another state. It's the same—same logic that I would use that he has the right to treat—I mean a physician under reimbursement is within the state but yet we certainly provide for physicians out of state to provide services. I don't see any difference.

Q But the statute doesn't say that, does it?

A Well, the statute doesn't say that they can provide services out of state, either.

Q Oh, the statute does specifically say, the manual which is incorporated by reference, you would agree that the manual—

A The reference is that out-of-state—it references out-of-state providers, implying that it expects out-of-state providers to be providing services, correct.

Q Okay. And it does specifically say that the requirements and the MRAs of this manual are not applicable to medical services rendered outside the State of Florida.

[16] A Right. The manual is a reimbursement manual. The requirements relative—are relating to reimbursement. Utilization review is not related to reimbursement. It is referenced only in the manual as a clarification to providers.

THE JUDGE: Ms. VanWinkle, let me interrupt you a minute.

MS. ROSSITTO-VanWINKLE: Uh-huh.

THE JUDGE: Before you started your Cross-Examination, I asked Ms. Frawley on what basis did they claim to have jurisdiction over these out-of-state doctors and she cited paragraph four of 440.13. And I think it's paragraph (i)(3). And this—this is something I'd like you to review real quickly because it—the statute says by accepting payment pursuant to this chapter for remedial treatment rendered to an injured employee a health care provider or health care facility shall be deemed to consent to submitting all necessary records and other information concerning such treatment to utilization review and peer review as provided by this section. Such health care provider shall further agree to comply with any decision of the Division pursuant to subparagraph four. And in paragraph four it talks about what the Division does, you know, when they're asked to do something.

[17] And what about the—it seems to me that that is a very important point to be addressed.

MS. ROSSITTO-VanWINKLE: It is, Your Honor.

THE JUDGE: It doesn't say Florida doctors.

MS. ROSSITTO-VanWINKLE: No, it says—but in the statute, in defining what a health care provider is and if you read at paragraph three in this, it specifically—I think—let me just get the right paragraph—where it's—it creates the three member panel to adopt the schedule for reimbursements and set forth the procedures for utilization review. If—imposes the obligation in duty upon them to—I mean, you know, no where in the Workers' Compensation statute does it say what is a—other than it defines a physician again as someone licensed under—a chiropractor licensed under chapter 460. And I believe the statute does define that as such.

THE JUDGE: Let me see that a minute.

MS. ROSSITTO-VanWINKLE: It defines—

MR. MOORE: Your Honor—

MS. ROSSITTO-VanWINKLE: Excuse me just a minute.

[18] MR. MOORE: I'm sorry. Michael Moore from the Department of Labor, Your Honor.

MS. ROSSITTO-VanWINKLE: Defines it—

MR. MOORE: Under that logic, though, the only providers who would be allowed to be authorized to treat patients in the State of Florida would be those providers licensed in the State of Florida and I'm sure any Judge of Compensation Claims will quickly be willing to point out that that wouldn't be right.

THE JUDGE: Okay. The—you know, let's start with basics. In the first place, Workers' Compensation is a creature of statute not common law. So if the statute itself sets out some rule of law with repsect to a particular event, then it controls over any kind of regulations or rules adopted by the Division of manuals or anything like that. So—

MR. MOORE: That's right, Your Honor.

THE JUDGE: —my concern at this point, the health care provider in the statute 440.13.(1)(b) says means a physician or any recognized practitioner who provides skills, services pursuant to the prescription of or under

the supervision or direction of a physician. It does not say Florida, Alabama, New York or whatever. And then you turn over here to this paragraph [19] that Ms. Frawley's talking about and it says that—that any health care provider that accepts payment under this chapter is deemed to have consented to submitting all necessary records for utilization review and agrees to be bound by whatever decision results.

Now that is fairly persuasive to me that—that the legislature has not differentiated between a Florida doctor versus a South Carolina doctor when they defined health care provider. Nor have they differentiated over here under the implied consent to be bound by this. And, you know, this not being bound by the fee schedule, that's not in the statute, is it? That's something that they did in the rules over there.

MS. ROSSITTO-VanWINKLE: If given time, Your Honor, I can probably produce some legislative history which will support—

THE JUDGE: Okay.

MS. ROSSITTO-VanWINKLE: —my position that the reason it's in there just the way it is, is because it's very clear that the State of Florida via statute or other authority, cannot assert jurisdiction over someone who does not have minimum contacts with the State of Florida. We have an out-of-state physician providing medical services to a Workers' Compensation claimant outside the State of Florida. There is a separate and individual contract [20] between the claimant and the doctor. Should the compensation carrier choose not to pay for those services, the claimant would still be responsible. The State of Florida could not prevent him from executing against Mr. Furtick in South Carolina for those services. In—

THE JUDGE: Now that's your strongest argument right there.

MS. ROSSITTO-VanWINKLE: Well, and I—

THE JUDGE: I—I agree with you because if it was in Florida, they could prevent him from executing.

MS. ROSSITTO-VanWINKLE: Absolutely.

THE JUDGE: But—

MS. ROSSITTO-VanWINKLE: And I agree and I think that that was the purpose behind the out-of-state medical services section of the file.

THE JUDGE: But, Ms. VanWinkle, it can't be just a carte blanche open-end—I mean this—this doctor might be the world's best chiropractor and every treatment he may have given could have been appropriate. I don't know. I haven't even gotten into the meat of it. But let's suppose that some claimant from Florida got into the hands of an unscrupulous doctor in another state and they went wild. They had him in every morning and every afternoon for six different modalities and [21] they were running up five thousand dollars a month in treatment. Is there no way it can be stopped?

MS. ROSSITTO-VanWINKLE: The claimant then is the person that has to be put on notice about his physician. And the way to do that is through the Workers' Compensation Claim Court, as just as we're here today, for a motion to de-authorize or reduce treatment based on a utilization review from another physician. But otherwise—because otherwise you're penalizing the claimant for a dispute—

MR. MOORE: No.

MR. LOWER: No, Your Honor.

MR. MOORE: No, no.

MS. ROSSITTO-VanWINKLE: —between a physician which is not subject to the jurisdiction of this Court.

MR. MOORE: —(incomprehensible)—going between the claimant and the physician, Your Honor. The claimant in this case doesn't have standing to represent the physician. In over-utilization review matters, the physician has to bring a petition before a—(incomprehensible) —hearing officer for a hearing, an administrative hearing in order to determine the merits of his or her particular case.

THE JUDGE: Well what she's [22] arguing, Mr. Moore, is that—we're talking about an eleven or twelve thousand dollar bill here, I think. And what she's saying is if it's submitted to the—to Ms. Frawley's unit over there for review and let's say they determine that six thousand was plenty and not twelve thousand, she's saying that her client then is subject to suit by the chiropractor for the other six thousand dollars and Florida can't stop it because they don't have any jurisdiction over citizens of South Carolina.

THE WITNESS: Your Honor?

THE JUDGE: Yes.

THE WITNESS: This is Molly Frawley.

THE JUDGE: Yes.

THE WITNESS: Historically, whenever there is a determination of over-utilization and a provider has money withheld from his for that or he's required to repay it, he cannot go back to the patient who received those services in good faith. Should he try, any licensing agency in any state of this nation would have his license so quick he couldn't spin around. You—a provider cannot go back onto a patient for his malfeasance.

THE JUDGE: Well, clearly they couldn't in Florida because it, you know, it says that they're bound by it and it's a misdemeanor go to back, I [23] believe, and try to collect.

THE WITNESS: It's a licensing issue. It has nothing to do with Workers' Compensation or anything else. It has to do with a physician's license.

MS. ROSSITTO-VanWINKLE: But if you—

THE WITNESS: And if a physician has been determined as over-utilizing and he wants to go back and make that patient pay for services the patient didn't need,—

THE JUDGE: What she's saying, Ms. Frawley, is that here's a doctor in South Carolina that says, you know, I didn't go down to Florida and ask for any business. Somebody was injured in Florida and they moved up here and they came in my office and asked me to

treat them and the insurance company authorized it and I began treating him and I ran up a bill and now they're looking backward on the bill in hindsight and saying you charged too much and we're not going to pay it and they sent it to some Florida chiropractor to give him an opinion and the Florida chiropractor didn't know anything about what's common in South Carolina among chiropractors or anybody else and—and Florida just doesn't have any, you know, any jurisdiction over me.

THE WITNESS: The final determination of over-utilization is made based upon peer [24] review. Peer review is based on a review by a physician from the same state that the physician's licensed in. I do not know this case fully, but should this case come to the Division, before the Division would make final findings, we would have opinions from a physician in the state from which the provider was practicing.

THE JUDGE: Okay. Well, that is some safeguard right there.

THE WITNESS: Pardon?

THE JUDGE: That is some safeguard right there in that he couldn't claim that you're running in some home cooking on me down there and—

THE WITNESS: Well, the definition of a peer is a physician licensed by the same agency. We have interpreted that to mean the same state agency. So in—in the Division's utilization review process, before we would go into final determination, we would have an opinion by a physician in that state.

THE JUDGE: Okay.

MS. ROSSITTO-VanWINKLE: Ms. Frawley, I have a couple of more questions.

THE WITNESS: Yes.

MS. ROSSITTO-VanWINKLE: (Continuing to the Witness.)

Q All right. Could you cite me to what [25] rules you're required to follow that forces you to have an out-

of-state physician review the services of another out-of-state physician?

A Doesn't force us to use it, but our interpretation of the word peer, which talks about a peer being a physician licensed by the same agency. Our interpretation of that is that the same licensing agency would be the agency in the same state; i.e., the Florida chiropractor would review a Florida chiropractor. And a North Carolina chiropractor would review a North Carolina chiropractor. It's in 440.13(1)(g). Okay?

Q Ms. Frawley—

A Now,—now, what the carrier does is the carrier is doing review before it gets to the Division. And it only makes sense that they would use consultants, not necessarily a full peer before they would go to the expense of going to a physician in another state. This is a concept in utilization review where you always review at the lowest level possible. And you only go up and use the more expensive expertise as you are convinced that your problem does, in fact, exist. So I don't know at what level this review is, but before the Division would take final action, we would have opinions from physicians in North Carolina.

Q I have one more—a couple more questions. Ms. Frawley—

[26] A Yes.

Q —is there any kind of requirement by the Division that before a health care provider from out-of-state provides services to a Florida Workers' Compensation claimant that he's advised that he will be subject to this utilization review?

A There is no place that providers in-state or out-of-state are advised of their application. The Florida law does say that by accepting payment they are agreeing to the provisions thereof. And—

Q So in—so in other—

A —pretty much in provider's licensing actions, they are supposed to—they are responsible for knowing the

rules and regulations of the different payer entities that they are involved in.

Q So in other words the State of Florida expects a South Carolina physician providing services to an individual living in South Carolina to read the Florida Statutes and decide whether or not he's going to care for this patient?

A Or to ask questions, yeah. I certainly would if I was going into a contractual arrangement with somebody I would want to know what was involved with it.

Q But if you were in a contractual relationship with a claimant, let's—let's—

[27] A Carrier; provider and carrier.

Q —let's forget about this. Let's forget it's a claimant or carrier. If you're a physician and you're providing services to an individual and he says I have insurance and you've been authorized by my insurance company for payment, what puts him on notice that he needs to make sure that he doesn't violate any laws of the state in which the insurance company is in?

A Physicians, when they accept insurance, take on the responsibility of finding out what the limitations and exclusions of those are. At the time of authorization we expect carriers and providers to discuss the limitations and exclusions. Often times this has not been done in the past. It is encouraged at this time. It is not in rule. But it's kind of a buyer-beware sort of situation as where as, you know, if you're going into a situation, you need to be asking. I mean the carriers are just as responsible as the providers are in this.

Q So in other words—

A But it hasn't always happened.

Q So in other words, a carrier who doesn't advise a physician of this commits fraud on the physician—

A No. No.

Q —by—by attempting to get their services and subjecting—

[28] A No more than a provider is committing fraud towards the carrier.

Q Would you let me finish my question? Would you let me finish my question? So in other words a carrier who doesn't up front advise a physician, an authorized physician, they could or may be subject to the statute of Florida and Florida's utilization review process by simply accepting payment, in effect commits fraud on that physician by not giving him the opportunity to say no.

A I would not agree with that.

Q Another question. You would agree that the statutes of the State of Florida are applicable and generated by the Florida Legislature; correct?

A That's my understanding.

Q And they're applicable in the State of Florida; correct?

A Yes.

Q Are they applicable to a citizen of South Carolina?

A If that citizen of South Carolina is carrying on business with the State of Florida, yes.

Q Oh, so, I see. So anyone who carries on—all right, strike that. How does—I have one more question.

MR. MOORE: Your Honor.—[29] Your Honor, I object. Where are we going?

THE JUDGE: Hold on.

MS. ROSSITTO-VanWINKLE: I have another question. (Continuing to the Witness.)

Q In your opinion, how is Dr. Phillips, who's providing care to Mr. Furtick in South Carolina and who is looking to Mr. Furtick for payment of this bill, should the insurance carrier refuse to pay and—how is he subjecting himself to the jurisdiciton of the Florida Division of Workers' Compensation?

MR. MOORE: Your Honor, I object. It's irrelevant. Why are we here?

THE JUDGE: Well, she's already answered that as best she can. She says by—by accepting payment under the Florida act that he's subject to whatever it says in the statutes here. Now let me ask you—let's shift gears a minute, Ms. VanWinkle. Is there—I don't know how

I'm going to rule on this. I'm going to give you a chance to supplement authority. I'm leaning at the moment to looking at the plain meaning of the statute, okay? Which doesn't seem to differentiate. Is there any possibility that Mr. Lower's client has not properly followed the steps—in other words at what point is he supposed to refer it to the Division of Workers' Comp and get them involved? Do you want to pursue that with Ms. [30] Frawley while she's on?

MS. ROSSITTO-VanWINKLE: Yes, I would. I would like to pursue that. (Continuing to the Witness.)

Q Once a physician—once a carrier denies payment of—to a physician on the basis of over-utilization—

A They don't deny based on over-utilization. They disallow the difference.

Q Oh, how is disallow different from deny payment?

A A disallowed bill is a bill that does not meet the requirements of reimbursement and medical necessity is set out in 440.13 as a requirement to meet reimbursement. And—

Q And what are those requirements?

A —and so that if a provider—if the carrier feels that the services cannot be justified as medically necessary, based on documentation, now we're talking reimbursement here only, okay, that the carrier must question medical necessity. If the documentation cannot support medical necessity, they disallow it on the explanation of medical benefits. This provides the provider an opportunity to—to ask for reconsideration to submit additional documentation. So this is for the reimbursement of the bill.

[31] Q I—yeah, I understand.

A Even though it's a reimbursement issue we consider it part and parcel of the utilization review process which, in parts, the concept of utilization review is that the carrier takes the least amount of action to affect the greatest amount of control. That is you put the doctor on notice, you let him know that you have concern, he

can ask questions, he can provide additional documentation, he can talk to the physician consultant. There's dialogue going on. In ninety to ninety-five percent of all cases there is a cooperative agreement between the health care provider and the carrier's consultants about what's reasonable and prudent and where they need to go. In those situations where the provider insists on continuing to provide care that he's not documenting as necessary in his records, we're not saying it's not necessary, but the documentation's not supporting it. Then the carrier must disallow it. There is a progression of steps that the carrier can follow.

Q Can we back up just for a minute. Let's start with the first refusal of payment.

A The first disallowance?

Q The first disallowance.

A Okay.

Q How long—what does the carrier's next [32] obligation and what length of time must that step be taken in?

A The carrier has forty-five days in which to deny or pay a claim. A disallowance is considered part of a payment. And so within forty-five days they must respond to that provider, tell him what they—what they have reimbursed, the amounts that they have refused or disallowed. That's in the reimbursement manual. It talks about the explanation of medical benefits being filed within forty-five days of receipt that identify the amounts that are reduced or disallowed.

Q Okay. And you would agree that Mr.—Dr. Phillips is not subject to any reimbursement reduction?

THE JUDGE: Well now, we've been through that.

MS. ROSSITTO-VanWINKLE: Well, but I just want to get that right here on the record together.

THE JUDGE: That's on the record. Let's get on—

THE WITNESS: Unless there was something agreed between him and the carrier beforehand.

MS. ROSSITTO-VanWINKLE: Okay. Now—

THE JUDGE: Let's follow these steps here.

MS. ROSSITTO-VanWINKLE: (Continuing to [33] the Witness.)

Q Now after the forty-five days—

A Okay.

Q —okay, do they have to then pay him or do what?

A They've done what they need to. He has sixty days in which to ask for a reconsideration. If he does not ask for a reconsideration, he's waived his rights to appeal.

Q Who advises him that he has sixty days to respond and what—what kind of documentation does the carrier need to have that they're properly advised the physician of these rights?

A Okay. The—these rights were defined in the rule when it was promulgated in May of '91. Since that time, the Division has encouraged carriers that there's nothing that requires carriers to advise the physician of this on the UMB. This is proposed in the new rules.

Q So in other words, unless they told him during that first forty-five day period that he had sixty days to respond after that forty-five day period, they—he had no idea what he was supposed to do.

A Probably not. Unless he had read the reimbursement manual or the rules.

Q And is there anything in your rules that [34] require carriers to provide out-of-state physicians with copies of the reimbursement manual?

A Not at this time.

Q Is there anything in your rules that requires carriers to provide out-of-state physicians supplying services with copies of even the rules of the Division?

A Not at this time. We consider that a provider responsibility. He accepts payment; it's his responsibility to know what the conditions are. If he asks for them, I'm sure the providers would provide it to him—or carriers would provide it to him.

Q On what basis do you find that it's his responsibility to find out about Florida law?

MR. MOORE: Your Honor, I'm going to have to object here. We've been through this. The law—

THE JUDGE: All right—

MR. MOORE: —every provider in all of the states are on notice that if they're providing services to Florida Workers' Compensation claimants, they'd better learn the laws in the—and the regulations in the manual that is applicable to the Workers' Compensation system in the State of Florida.

THE JUDGE: Okay. Ms. [35] VanWinkle, I—I agree with Mr. Moore's objection on that. I—they—they—I don't think Ms. Frawley can answer it any—any better than she already has. They take the position that health care providers, by accepting payment under this law, subjects them to certain procedures under this law, particularly including over-utilization. I know you don't agree with that. I don't know whether I agree with it or not. I haven't reached that point. But in any event, that's their position. She's also said that they encourage employer/carriers to make the health care providers aware of these procedures, but they don't require it, okay? So that's their position.

Now let's go to step three. Let's say the doctor does ask for reconsideration within sixty days. Go ahead and pick it up from there.

THE WITNESS: To you want me to talk?

MS. ROSSITTO-VanWINKLE: (Continuing to the Witness.)

Q What happens at step three?

A Okay. Once the provider has requested a reconsideration of a carrier, the carrier has sixty days in which to respond to that reconsideration and that's in the dispute rule. It's referenced in the reimbursement manual, [36] but there's a very specific rule that addresses the sixty days, sixty days and sixty days. The carrier must respond with their reconsideration request within sixty

days. The provider, within sixty days of receiving the reconsideration determination, if he still does not agree with that, can appeal to the Division. The Division then has sixty days in which to respond to the provider and give him a definitive answer. If the carrier fails to respond to a request for reconsideration, then ninety days after the request for reconsideration, a provider can come directly to the Division and advise us the carrier has failed to reconsider and they're asking for a resolution of the reimbursement dispute.

Q And what happens if during this time period a physician were to deny medical services to the claimant for failure to pay?

A I would expect the provider to be looking closely at the services he's providing and the documentation he's keeping to ensure that he's providing only medically necessary services and if they are medically necessary services, they're adequately documented as such.

Q I believe you misunderstood my question. What happens to a health care provider who stops providing services during this procedure?

A Has he abandoned the patient; is this [37] what we're talking about?

Q No, he simply refuses to treat for failure to pay the bill.

A He's abandoned the patient.

Q No, he has not abandoned the patient.

THE JUDGE: Well, let's—this is getting into semantics. She considers terminating treatment abandonment. You don't. But—

MS. ROSSITTO-VanWINKLE: Well—but she also considers failure to pay as—what was her term—a disallowance as opposed to denial of coverage.

THE JUDGE: Well, okay. Ms. Frawley, if you want to characterize it as abandonment, look at it—answer the question from that perspective then.

THE WITNESS: Okay. If—if the provider fails to provide treatment to the claimant and the claimant ad-

vises the adjustor of this, the adjustors normally will provide them with alternate care.

MS. ROSSITTO-VanWINKLE: (Continuing to the Witness.)

Q What about if the physician just says I'll continue to provide it if you'll guarantee the payment? And the claimant says he will.

A That's between—that's between the claimant and the provider at that point in time.

[38] THE JUDGE: Okay, let's—

MS. ROSSITTO-VanWINKLE: (Continuing to the Witness.)

Q Why—all right, let's go one more step.

A Has the provider told the claimant why he's not getting paid?

Q Wait a minute. One more step here. Why, then, when the claimant in an out-of-state situation goes to a physician whom his carrier refers him to and says, you know, you're to treat me and the physician says yes, your carrier's authorized me to treat you, and he treats him and the claimant then is required to guarantee the services just as in any other situation with insurance. When you go into the hospital, you say—they say will you accept my insurance, you say—the hospital says yes, subject to, you know, but you're the one that's ultimately responsible for the bill; is that not correct?

MR. MOORE: Your Honor, can you repeat the question there? I'm sorry, Counselor.

MS. ROSSITTO-VanWINKLE: (Continuing to the Witness.)

Q Let me try it one more time. How is this situation any different from any other insurance situation where an individual goes to a physician and says will you accept my insurance? And the physician agrees to accept [39] the insurance—

A Okay.

Q —but the individual is ultimately responsible.

A If I have a patient go into a hospital and the hospital calls my insurance and gets—

Q Authorization.

A —certification for me to be treated—

Q Correct.

A —that does not allow that hospital carte blanche privilege to provide me anything that I need. If that hospital comes to me and says your doctor would like us to remove the mole on your left ear but your insurance company is not going to pay for it and I say fine, I'll pay for it myself, I'm responsible for it. If the doctor, while he has me under anesthesia, removes it anyhow, and hasn't told me that it's not going to be covered by the insurance, then I don't have to pay for it, they're holding the bag. They need to have specific authorization for that. Authorization is not carte blanche. It's authorization to provide only the services that are medically necessary.

Q Has anyone advised Mr. Furtick at any time that any of this care was in any way even questioned?

THE JUDGE: Okay, now she can't—she can't answer that—

[40] MS. ROSSITTO-VanWINKLE: All right, let me strike that.

THE JUDGE: —'cause she's not the—

MR. MOORE: It's irrelevant, Your Honor.

MS. ROSSITTO-VanWINKLE: Let me ask—all right, let me strike the question and re-ask it.

THE JUDGE: She's not familiar with this particular case.

MS. ROSSITTO-VanWINKLE: (Continuing to the Witness.)

Q What provisions in the Division or rules or regulations require the carrier to give notice to the claimant that the treatment he is receiving is being questioned?

A There is no provision. I do not anticipate any provision. This is a provider issue. The claimant is not involved. The claimant's not required to pay. The carrier

puts the provider on notice. It is the provider's responsibility at that point in time to dialogue with the carrier to find out what the problem is. It's not a claimant issue.

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